FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0035204

Facility Name: Rosewood Care Center-East Peoria

Address: 900 Centennial Drive (Number) East Peoria (City) 61611 (Zip Code)

County: Tazewell

Telephone Number: (309) 699-5400 **Fax #** ( )

IDPA ID Number: 431446788001

Date of Initial License for Current Owners: 04/18/89

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Cindy A. Tefteller **Telephone Number:** (618) 465-7717

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/1999 to 06/30/2000 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) See Accountants' Compilation Report (Date)
(Print Name and Title) Cindy A. Tefteller
(Firm Name & Address) C.J. Schlosser & Company, 233 East Center Drive, Alton, IL 62002
(Telephone) (618) 465-7717 Fax (618) 465-7710

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Print Previe

Facility Name & ID Number Rosewood Care Center-East Peoria # 0035204 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	120	Skilled (SNF)	120	43,920	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	120	TOTALS	120	43,920	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			6,238	6,238	8
9	SNF/PED					9
10	ICF	5,999	14,710		20,709	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	5,999	14,710	6,238	26,947	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4 61.35%

D. How many bed-hold days during this year were paid by Public Aid? 0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/19/89

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/19/89 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 42 and days of care provided 6238

Medicare Intermediary Tri-Span

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/2000 Fiscal Year: 06/30/2000

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Print Previe

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Rosewood Care Center-East Peoria # 0035204 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	158,307	11,528	8,372	178,207		178,207	0	178,207			1
2	Food Purchase		121,365		121,365		121,365	(6,577)	114,788			2
3	Housekeeping	100,971	18,218		119,189		119,189	0	119,189			3
4	Laundry	35,598	11,612		47,210		47,210	0	47,210			4
5	Heat and Other Utilities			99,707	99,707		99,707	0	99,707			5
6	Maintenance	26,623	14,797	46,397	87,817		87,817	2,793	90,610			6
7	Other (specify): Sanitation			25,232	25,232		25,232	0	25,232			7
8	TOTAL General Services	321,499	177,520	179,708	678,727		678,727	(3,784)	674,943			8
	B. Health Care and Programs											
9	Medical Director			4,300	4,300		4,300	0	4,300			9
10	Nursing and Medical Records	1,259,935	137,990	30,144	1,428,069		1,428,069	0	1,428,069			10
10a	Therapy	37,537	3,787	351,990	393,314		393,314	41,506	434,820			10a
11	Activities	37,591	3,527	3,158	44,276		44,276	0	44,276			11
12	Social Services	39,542		3,979	43,521		43,521	0	43,521			12
13	Nurse Aide Training							0				13
14	Program Transportation							0				14
15	Other (specify):*							0				15
16	TOTAL Health Care and Progra	1,374,605	145,304	393,571	1,913,480		1,913,480	41,506	1,954,986			16
	C. General Administration											
17	Administrative			141,934	141,934		141,934	(54,643)	87,291			17
18	Directors Fees							0				18
19	Professional Services			5,103	5,103		5,103	47,490	52,593			19
20	Dues, Fees, Subscriptions & Promotions			25,369	25,369		25,369	(7,351)	18,018			20
21	Clerical & General Office Expense	105,545	22,322	26,841	154,708		154,708	151,916	306,624			21
22	Employee Benefits & Payroll Taxes			257,861	257,861		257,861	22,649	280,510			22
23	Inservice Training & Education							0				23
24	Travel and Seminar			1,614	1,614		1,614	(39)	1,575			24
25	Other Admin. Staff Transportation			6,688	6,688		6,688	12,543	19,231			25
26	Insurance-Prop.Liab.Malpractice			28,885	28,885		28,885	3,226	32,111			26
27	Other (specify):*							0				27
28	TOTAL General Administration	105,545	22,322	494,295	622,162		622,162	175,791	797,953			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,801,649	345,146	1,067,574	3,214,369		3,214,369	213,513	3,427,882			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000. SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Previe

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

Facility Name & ID Number Rosewood Care Center-East Peoria # 0035204 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			10,783	10,783		10,783	163,120	173,903			30
31	Amortization of Pre-Op. & Org.							9,053	9,053			31
32	Interest			61,855	61,855		61,855	253,855	315,710			32
33	Real Estate Taxes			56,035	56,035		56,035	0	56,035			33
34	Rent-Facility & Grounds			495,745	495,745		495,745	(486,810)	8,935			34
35	Rent-Equipment & Vehicles							0				35
36	Other (specify):*							0				36
37	TOTAL Ownership			624,418	624,418		624,418	(60,782)	563,636			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation							0				38
39	Ancillary Service Centers		105,011	19,524	124,535		124,535	(2,221)	122,314			39
40	Barber and Beauty Shops			15,966	15,966		15,966	0	15,966			40
41	Coffee and Gift Shops							0				41
42	Provider Participation Fee			65,880	65,880		65,880	0	65,880			42
43	Other (specify):*							0				43
44	TOTAL Special Cost Centers		105,011	101,370	206,381		206,381	(2,221)	204,160			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,801,649	450,157	1,793,362	4,045,168	0	4,045,168	150,510	4,195,678			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Print Previe

SEE ACCOUNTANTS' COMPILATION REPORT

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

Facility Name & ID Number Rosewood Care Center-East Peoria # 0035204 Report Period Beginning: 07/01/1999 Ending: 6/30/2000

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,249)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds	(2,221)	39		11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(328)	2		13
14	Non-Care Related Interest	(61,855)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(3,000)	20		17
18	Fines and Penalties				18
19	Entertainment	(39)	24		19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,142)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(2,209)	20		28
29	Other-Attach Schedule Marketing Salary	(38,302)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (116,345)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in th general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	266,855	Var	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 266,855		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 150,510		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Print Previe

ıe

Detail lines 29 and 35 of Page 5 starting in B44 DO NOT DRAG AND DROP CELLS.
The amounts in columns F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

To Print the Other Adjustments you have entered.
1. **Highlight the other adjustments you have entered starting at B44 and continue to your last entry. Be sure the columns highlighted are B thru G.**
2. **Push the Print Other Adjustments button.**

STATE OF ILLINOIS **Page 5A**

Facility Name Rosewood Care Center-East Peoria
IDPH 0025284
Report Period Beginning: 07/01/1999
Ending: 06/30/2000

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	Sch V	Adj. Summary
The information listed in B13 thru G43 is from Page 5.					
1	**Day Care**	0	0	**Line 1**	0
2	**Other Care for Outpatients**	0	0	**Line 2**	(6,372)
3	**Governmental Sponsored Special Programs**	0	0	**Line 3**	0
4	**Non-Patient Meals**	(6,249)	2	**Line 4**	0
5	**Telephone, TV & Radio in Resident Rooms**	0	0	**Line 5**	0
6	**Rented Facility Space**	0	0	**Line 6**	0
7	**Sale of Supplies to Non-Patients**	0	0	**Line 7**	0
8	**Laundry for Non-Patients**	0	0	**Line 8**	(6,372)
9	**Non-Straightline Depreciation**	0	0	**Line 9**	0
10	**Interest and Other Investment Income**	0	0	**Line 10**	0
11	**Discounts, Allowances, Rebates & Refunds**	(2,221)	39	**Line 10a**	0
12	**Non-Working Officer's or Owner's Salary**	0	0	**Line 11**	0
13	**Sales Tax**	(328)	2	**Line 12**	0
14	**Non-Care Related Interest**	(61,855)	32	**Line 13**	0
15	**Non-Care Related Owner's Transactions**	0	0	**Line 14**	0
16	**Personal Expenses (Including Transportation)**	0	0	**Line 15**	0
17	**Non-Care Related Fees**	(3,000)	20	**Line 16**	0
18	**Fines and Penalties**	0	0	**Line 17**	0
19	**Entertainment**	(39)	24	**Line 18**	0
20	**Contributions**	0	0	**Line 19**	0
21	**Owner or Key-Man Insurance**	0	0	**Line 20**	(7,221)
22	**Special Legal Fees & Legal Retainers**	0	0	**Line 21**	(58,702)
23	**Malpractice Insurance for Individuals**	0	0	**Line 22**	0
24	**Bad Debt**	0	0	**Line 23**	0
25	**Fund Raising, Advertising and Promotional**	(2,142)	20	**Line 24**	330
26	**Income & IL Personal Property Replacement T**	0	0	**Line 25**	0
27	**Nurse Aide Training for Non-Employees**	0	0	**Line 26**	0
28	**Yellow Page Advertising**	(2,209)	20	**Line 27**	0
29	**Non-Paid Workers**	0	0	**Line 28**	(45,695)
30	**Donated Goods**	0	0	**Line 29**	(52,209)
31	**Amortization Expense**	0	0	**Line 30**	0
32	Eliminate Marketing Salary	(38,302)	21	**Line 31**	0
				Line 32	(61,855)
				Line 33	0
				Line 34	0
				Line 35	0
				Line 36	0
				Line 37	(61,855)
				Line 38	0
				Line 39	(2,221)
				Line 40	0
				Line 41	0
				Line 42	0
				Line 43	0
				Line 44	(2,221)
				Line 45	(116,349)

Print Other Adjustment

Reference 1	Reference 2	Reference 3	Reference 4	Reference 5	Reference 6	Reference 7	Reference 9	Reference 10	Reference 10a	Reference 11	Reference 12	Reference 13	Reference 14	Reference 15	Reference 17	Reference 18	Reference 19	Reference 20	Reference 21	Reference 22	Reference 23	Reference 24	Reference 25	Reference 26	Reference 27	Reference 30	Reference 31	Reference 32	Reference 33	Reference 34	Reference 35	Reference 36	Reference 38	Reference 39	Reference 40	Reference 41	Reference 42	Reference 43

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary A

Facility Name & ID Numb Rosewood Care Center-East Peoria # 0035204 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,577)	0	0	0	0	0	0	0	0	0	0	(6,577)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	2,793	0	0	0	0	0	0	0	0	2,793	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,577)	0	2,793	0	0	0	0	0	0	0	0	(3,784)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	41,506	0	0	0	0	0	0	0	0	0	41,506	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Program**	0	41,506	0	0	0	0	0	0	0	0	0	41,506	16
	C. General Administration													
17	Administrative	0	(121,934)	67,291	0	0	0	0	0	0	0	0	(54,643)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	2,187	45,303	0	0	0	0	0	0	0	0	47,490	19
20	Fees, Subscriptions & Promotions	(7,351)	0	0	0	0	0	0	0	0	0	0	(7,351)	20
21	Clerical & General Office Expenses	(38,302)	100	190,118	0	0	0	0	0	0	0	0	151,916	21
22	Employee Benefits & Payroll Taxes	0	290	22,359	0	0	0	0	0	0	0	0	22,649	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(39)	0	0	0	0	0	0	0	0	0	0	(39)	24
25	Other Admin. Staff Transportation	0	0	12,543	0	0	0	0	0	0	0	0	12,543	25
26	Insurance-Prop.Liab.Malpractice	0	0	3,226	0	0	0	0	0	0	0	0	3,226	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(45,692)	(119,357)	340,840	0	0	0	0	0	0	0	0	175,791	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(52,269)	(77,851)	343,633	0	0	0	0	0	0	0	0	213,513	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS — Summary B

Facility Name & ID Numb: Rosewood Care Center-East Peoria # 0035204 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	145,416	17,704	0	0	0	0	0	0	0	0	163,120	30
31	Amortization of Pre-Op. & Org.	0	9,053	0	0	0	0	0	0	0	0	0	9,053	31
32	Interest	(61,855)	315,710	0	0	0	0	0	0	0	0	0	253,855	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(495,745)	8,935	0	0	0	0	0	0	0	0	(486,810)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(61,855)	(25,566)	26,639	0	0	0	0	0	0	0	0	(60,782)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(2,221)	0	0	0	0	0	0	0	0	0	0	(2,221)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Cent	(2,221)	0	0	0	0	0	0	0	0	0	0	(2,221)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(116,345)	(103,417)	370,272	0	0	0	0	0	0	0	0	150,510	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE ACCOUNTANTS' COMPILATION REPORT

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Numbe Rosewood Care Center-East Peoria # 0015204 Report Period Beginning 07/01/1999 Ending: 06/30/2000

Show Pgs 6A thru 6 | Show Pgs 6E thru 6 | Hide Pgs 6A thru 6

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Larry Vander Maten	75.00%	See Attached List		See Attached List		
Darrell Herring	25.00%	See Attached List		See Attached List		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6
1	V	17 Management Fee	$ 141,934	HNM Management Services, Inc	100.00%	$	$ (141,934)	1	-141934
2	V							2	
3	V	10a Therapy	252,990	Rosewood Therapy Services, Inc	0.00%	292,496	41,506	3	41506
4	V							4	
5	V	34 Rent	495,745	East Peoria Real Estate, Inc.	0.00%		(495,745)	5	-495745
6	V	20 Depreciation		East Peoria Real Estate, Inc.		145,416	145,416	6	145416
7	V	32 Interest		East Peoria Real Estate, Inc.		315,710	315,710	7	315710
8	V	21 Amortization - Loan Fee		East Peoria Real Estate, Inc.		9,053	9,053	8	9053
9	V	19 Professional Fees		East Peoria Real Estate, Inc.		2,187	2,187	9	2187
10	V	17 Owners Compensation		East Peoria Real Estate, Inc.		20,000	20,000	10	20000
11	V	22 Payroll Taxes		East Peoria Real Estate, Inc.		290	290	11	290
12	V	21 Office Expense		East Peoria Real Estate, Inc.		100	100	12	100
13	V							13	
14	Total		$ 989,669			$ 886,252	$ * (103,417)	14	

* Total must agree with the amount recorded on line 34 of Schedule V SEE ACCOUNTANTS' COMPILATION REPORT

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

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5. The adjustments entered on this page will automatically transfer to the summary pages.

Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line	Line
1	2	3	4	5	6	7	9	10	10a	11	12	13	14	15	17	18	19	20	21	22	23	24	25	26	27	30	31	32	33	34	35	36	38	39	40	41	42	43

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SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number Rosewood Care Center-East Peoria # 0035204 Report Period Beginnin 07/01/1999 Ending: 06/30/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)		Sum_6A
15	V	17	See Schedule VIII	$	Hsm Management Services, Inc	100.00%	$ 67,291	$ 67,291	15	67291
16	V	21	See Schedule VIII		HSM Management Services, Inc.	100.00%	190,118	190,118	16	190118
17	V	22	See Schedule VIII		HSM Management Services, Inc.	100.00%	22,359	22,359	17	22359
18	V	25	See Schedule VIII		HSM Management Services, Inc.	100.00%	12,543	12,543	18	12543
19	V	30	See Schedule VIII		HSM Management Services, Inc.	100.00%	17,704	17,704	19	17704
20	V	34	See Schedule VIII		HSM Management Services, Inc.	100.00%	8,935	8,935	20	8935
21	V	19	See Schedule VIII		HSM Management Services, Inc.	100.00%	45,303	45,303	21	45303
22	V	26	See Schedule VIII		HSM Management Services, Inc.	100.00%	3,226	3,226	22	3226
23	V	6	See Schedule VIII		HSM Management Services, Inc.	100.00%	2,793	2,793	23	2793
24	V								24	
25	V								25	
26	V								26	
27	V								27	
28	V								28	
29	V								29	
30	V								30	
31	V								31	
32	V								32	
33	V								33	
34	V								34	
35	V								35	
36	V								36	
37	V								37	
38	V								38	
39	Total			$			$ 370,272	$ * 370,272	39	

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

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Print Page 6

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STATE OF ILLINOIS

Facility Name & ID Number Rosewood Care Center-East Peoria # 0035204 Report Period Beginnin 07/01/1999 Ending: 06/30/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6B

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

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Print Page 6

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STATE OF ILLINOIS

Facility Name & ID Number Rosewood Care Center-East Peoria # 0035204 Report Period Beginnin 07/01/1999 Ending: 06/30/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V				$			$	$	15
16	V									16
17	V									17
18	V									18
19	V									19
20	V									20
21	V									21
22	V									22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$			$	$ *	39

Sum_6C

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Rosewood Care Center-East Peoria # 0035204 Report Period Beginnin 07/01/1999 Ending: 06/30/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI. SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Rosewood Care Center-East Peoria # 0035204 Report Period Beginnin 07/01/1999 Ending: 06/30/2000

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Larry Vander Maten	President	Management	75.00%	443,431	3	5.62%	Salary	$ 26,381	17-8	1
2	Darrell Hoefling	Vice-President	Management	25.00%	158,479	3	5.62%	Salary	12,794	17-8	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 39,175		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

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the name(s)
PORTS.

Facility Name & ID Number Rosewood Care Center-East Peoria # 0035204 Report Period Beginning: 07/01/1999 Ending: 6/30/2000

VIII. ALLOCATION OF INDIRECT C

Show Pgs 8A thru 8 | Show Pgs 8E thru 8 | Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organizatio: HSM Management Services, Inc.
Street Address: 11701 Borman Drive, Suite 315
City / State / Zip Code: St. Louis, MO 63146
Phone Number: (314) 994-9070
Fax Number: (314) 994-9912

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	Salaries - Officers	Total Cost	63,328,031	17	$ 341,083	$ 341,083	3,560,142	$ 19,175	1
2	21	Salaries - Other	Total Cost	63,328,031	17	2,916,125	2,916,125	3,560,142	163,937	2
3	22	Payroll Taxes	Total Cost	63,328,031	17	221,266		3,560,142	12,439	3
4	22	Employee Benefits	Total Cost	63,328,031	17	87,376		3,560,142	4,912	4
5	25	Travel	Total Cost	63,328,031	17	123,502		3,560,142	6,943	5
6	30	Depreciation	Total Cost	63,328,031	17	273,812		3,560,142	15,393	6
7	34	Building Rent	Total Cost	63,328,031	17	158,940		3,560,142	8,935	7
8	19	Professional Services	Total Cost	63,328,031	17	805,860		3,560,142	45,303	8
9	21	Telephone	Total Cost	63,328,031	17	167,133		3,560,142	9,396	9
10	26	Insurance	Total Cost	63,328,031	17	57,385		3,560,142	3,226	10
11	21	Taxes & Licenses	Total Cost	63,328,031	17	7,008		3,560,142	394	11
12	21	Office Supplies	Total Cost	63,328,031	17	291,559		3,560,142	16,391	12
13	6	Maintenance	Total Cost	63,328,031	17	46,996		3,560,142	2,642	13
14	17	Direct - Admin	Direct Cost	1	1	48,116	48,116	1	48,116	14
15	17	Direct - Admin	Direct Cost	16	16	920,437	920,437	0	0	15
16	22	Direct - Payroll Taxes	Direct Cost	1	1	5,008		1	5,008	16
17	22	Direct - Payroll Taxes	Direct Cost	16	16	93,169		0	0	17
18	30	Direct - Depreciation	Direct Cost	1	1	2,311		1	2,311	18
19	30	Direct - Depreciation	Direct Cost	16	16	30,199		0	0	19
20	25	Direct - Travel	Direct Cost	1	1	5,600		1	5,600	20
21	25	Direct - Travel	Direct Cost	16	16	228,199		0	0	21
22	6	Direct - Maintenance	Direct Cost	1	1	151		1	151	22
23	6	Direct - Maintenance	Direct Cost	16	16	8,278		0	0	23
24										24
25	TOTALS					$ 6,839,513	$ 4,225,761		$ 370,272	25

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Rosewood Care Center-East Peoria # 0035204 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bonds		X	Refinance Mortgage		10/21/93	$ 5,498,000	$ 0	N/A	7.25%	$ 71,301	1
2	Bank of America		X	Refinance Bonds	$35,233.00	10/26/99	4,027,366	4,005,399	11/2009	8.89%	259,895	2
3	Less: Related Party Interest Income Offset										(15,486)	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$35,233.00		$ 9,525,366	$ 4,005,399			$ 315,710	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 9,525,366	$ 4,005,399			$ 315,710	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Numbe Rosewood Care Center-East Peoria # 0035204 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	72,800	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	65,635	2
3. Under or (over) accrual (line 2 minus line 1).	$	(7,165)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	63,200	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	56,035	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	55,303	8
	1996	59,292	9
	1997	62,971	10
	1998	69,551	11
	1999	61,719	12

1998 Payment $34,776

1999 Payment $30,859

Accrual = Remaining 1999 Tax Bill (30,800) + 1/2 of estimated 2000 tax bill (32,400)

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATIC	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Numb Rosewood Care Center-East Peoria # 0035204 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 39,125 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [ ] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 245,232
2. Number of Years Over Which it is Being Amortized: Bond Costs Written Off Over Life of Bon
3. Current Period Amortization: 9,053
4. Dates Incurred: Bonds Issued Oct. 1993

Nature of Costs: Bond Loan Fee - $241,750; Org. Costs - $1,260; Bond Trustee Fee - $2,222
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	7123 Acres	1988	$ 85,906	1
2					2
3	TOTALS			$ 85,906	3

SEE ACCOUNTANTS' COMPILATION REPORT

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ıds

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12 | Show Pgs 12C and 12 | Hide Pgs 12A thru 12

STATE OF ILLINOIS

Facility Name & ID Number Rosewood Care Center-East Peoria # 0035204 Report Period Beginning: 07/01/1995 Ending: 06/30/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	120			1989	$ 2,953,579	$	10-25	$ 123,806	$ 123,806	$ 1,525,518	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Improvements - Original Construction			1989	209,624		15-25	10,276	10,276	115,606	9
10	Fence			1990	2,377		25	95	95	855	10
11	Concrete Work			1991	5,190		25	208	208	1,872	11
12	Painting			1992	7,694		5	0		7,694	12
13	Irrigation System			1993	10,175		25	407	407	2,883	13
14	Generator			1989	14,937		10			14,937	14
15	Signs			1989	3,157		10			3,157	15
16	Walk-In Cooler			1989	5,770		20	289	289	3,251	16
17	Sinks			1989	3,744		10			3,744	17
18	Exhaust Hood			1989	4,621		10			4,621	18
19	Fire System			1989	1,271		20	64	64	720	19
20	Carpeting			1989	10,368		10			10,368	20
21	Cubicle Track			1989	6,294		10			6,294	21
22	Door Installation			1991	2,750		10	275	275	2,406	22
23	Sprinkler Addition			1992	786		10	79	79	672	23
24	Ceramic Sink			1994	2,011		10	201	201	1,139	24
25											25
26	Leasehold Improvements - Facility:										26
27	Carpeting			1994	3,238	463	7	463		2,894	27
28	Painting, Baseboard Stripping, Drapery, Tile, Carpet			1995	37,083	5,297	7	5,297		28,293	28
29	Painting			1996	3,960	565	7	565		2,200	29
30	Wallpaper			1998	3,525	504	7	504		1,134	30
31	Floor Covering/Wallpaper/Plants			1998	18,546	2,649	7	2,649		4,448	31
32	Mini Blinds/Wallcovering			1999	5,486	784	7	784		990	32
33	Carpeting			1999	4,375	521	7	521		521	33
34											34
35	Continued on Additional Page										35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$ 10,783		$ 146,483	$ 135,700	$ 1,746,217	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

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STATE OF ILLINOIS

Facility Name & ID Numbe Rosewood Care Center-East Peoria # 0035204 Report Period Beginning: 07/01/1995 Ending: 06/30/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9	Leasehold Improvements - Management Company										9
10	Office Construction / Improvements			1995	430		5	86	86	430	10
11	Office Design			1995	39		5	9	9	39	11
12	Office Shelving			1996	92		4	22	22	92	12
13	Office Expansion			1996	406		4	102	102	406	13
14	Office Expansion			1997	1,088		3	345	345	1,088	14
15	Office Expansion			1998	614		3	205	205	365	15
16	Office Addition			1999	303		3	101	101	101	16
17	Door Locks			1999	151		3	29	29	29	17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$ 899	$ 899	$ 2,550	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

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IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Facility Name & ID Numbe Rosewood Care Center-East Peoria # 0035204 Report Period Beginning: 07/01/1995 Ending: 06/30/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3				$ #VALUE!	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

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Facility Name & ID Number Rosewood Care Center-East Peoria # 0035204 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componen Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 193,197	$	$ 18,581	$ 18,581	5-7 Yrs	$ 115,688	37
38	Current Year Purchases	14,808		1,165	1,165		1,165	38
39	Fully Depreciated Assets	339,662					339,662	39
40								40
41	TOTALS	$ 547,667	$	$ 19,746	$ 19,746		$ 456,515	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	HSM Management	Various	Various	$ 39,578	$	$ 6,775	$ 6,775	5 Yrs	$ 15,784	42
43										43
44										44
45										45
46	TOTALS			$ 39,578	$	$ 6,775	$ 6,775		$ 15,784	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$	#VALUE!	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$	10,783	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$	173,903	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	163,120	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$	2,221,066	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Section Not Applicable	$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58	Section Not Applicable	$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

SEE ACCOUNTANTS' COMPILATION REPORT

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XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease Schedule Not Applicable

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. _____
This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: ☐ YES ☐ NO Terms: _____ *

10. Effective dates of current rental agreement:
Beginning _____
Ending _____

11. Rent to be paid in future years under the curre
rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipm $ _____ Description: _____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Rosewood Care Center-East Peoria # 0035204 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

SCHEDULE NOT APPLICABLE - ONLY HIRE CERTIFIED AII
If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
IN-HOUSE PROGRAM ☐
IN OTHER FACILITY ☐
COMMUNITY COLLEGE ☐
HOURS PER AIDE ___

3. CLINICAL PORTION:
IN-HOUSE PROGRAM ☐
IN OTHER FACILITY ☐
HOURS PER AIDE ___

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income y
facility received training aides from other faciliti

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Rosewood Care Center-East Peoria # 0035204 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service		Cost	Outside Practitioner (other than consultant) Units		Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a-8	hrs		$	10,468	$	96,904	$	10,468	$ 96,904	1
2	Licensed Speech and Language Development Therapist	10a-8	hrs			1,452		5,487		1,452	5,487	2
3	Licensed Recreational Therapist		hrs									3
4	Licensed Physical Therapist	10a-8	hrs			19,368		291,106	3,787	19,368	294,893	4
5	Physician Care		visits									5
6	Dental Care		visits									6
7	Work Related Program		hrs									7
8	Habilitation		hrs									8
9	Pharmacy	39-8	# of prescrpts						105,011		105,011	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs									10
11	Academic Education		hrs									11
12	Exceptional Care Program											12
13	X-Ray, Ambulance, Specialty Beds & Other (specify): Lab Fees	39-8						17,303			17,303	13
14	TOTAL				$	31,288	$	410,800	$ 108,798	31,288	$ 519,598	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Rosewood Care Center-East Peoria # 0035204 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 06/30/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 257,057	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 44,000)	671,599		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,516		6
7	Other Prepaid Expenses	2,886		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Deferred Income Tax Benefit	14,000		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 958,058	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	76,213		15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)	(40,480)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 35,733	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 993,791	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 164,641	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	810,637		29
30	Accrued Salaries Payable	143,078		30
31	Accrued Taxes Payable (excluding real estate taxes)	16,631		31
32	Accrued Real Estate Taxes(Sch.IX-B)	63,200		32
33	Accrued Interest Payable	45,893		33
34	Deferred Compensation			34
35	Federal and State Income Taxes	(1,000)		35
	Other Current Liabilities(specify):			
36	Accrued Management Fees	1,892		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,244,972	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,244,972	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (251,181)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 993,791	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

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Facility Name & ID Number Rosewood Care Center-East Peoria # 0035204 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (237,514)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (237,514)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(13,667)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (13,667)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (251,181)	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

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Facility Name & ID Number Rosewood Care Center-East Peoria # 0035204 Report Period Beginning: 07/01/1999 Ending: 06/30/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,060,981	1
2	Discounts and Allowances for all Levels	(1,530,066)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,530,915	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,452,218	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,452,218	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	19,947	13
14	Non-Patient Meals	6,249	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thr**	$ 26,196	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	8,540	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and**	$ 8,540	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28	**Miscellaneous Other Income**	2,411	28
28a	**Lab Discount**	2,221	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 4,632	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 2**	$ 4,022,501	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	$ 678,727	31
32	Health Care	1,913,480	32
33	General Administration	622,162	33
	B. Capital Expense		
34	Ownership	624,418	34
	C. Ancillary Expense		
35	Special Cost Centers	140,501	35
36	Provider Participation Fee	65,880	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,045,168	40
41	**Income before Income Taxes (line 30 minus line 40)****	(22,667)	41
42	**Income Taxes**	9,000	42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus**	$ (13,667)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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